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COVER PLATE

The photo on the cover, illustrating principles of occupational health and safety, is presented through the courtesy of R. L. Crain, Ltd. Ottawa, Ontario.

PHYSICIANS INDOCTRINATION C.D. "COURSE 104"

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Editor's Note:

The following article is a brief summary of the personal reflections of the author on the first Physicians Civil Defence Indoctrination Course, which he attended in March 1955.

Perhaps by his very nature, the average doctor of medicine is often a somewhat wary sceptic. From his teaching, and experience, he has become conservative and cautious of accepting new ideas which appear as unproven claims or theories. For this reason, there is no doubt that many of the forty-one doctors coming to Arnprior for the first Physicians Indoctrination Course, arrived with a faintly cynical attitude, begrudging the time to be spent on "this civil defence fad" and expecting to gain and learn nothing.

This feeling of "reserved hostility" received a decided jolt the very first evening, when we were received with quiet efficiency by the patient, hard-working staff of the college. They maintained an amazing standard with brisk cheerfulness throughout the week, even though there were three different courses being conducted, and there were more students in residence than had ever previously been accommodated. The physical

surroundings, too, were reassuring. To many of us, the service-like atmosphere made it seem as if we were "in" again; and, though many may find it hard to understand, there is much "peace" to be found in the ordered routine of service life, particularly for the phone-ridden physician.

By the following morning, "Class 104" was complete. Here, it may be mentioned, another interesting sidelight on the medical profession was revealed. The strange phenomenon, which sees the transformation of the notoriously wild student, the Medic, to that most respected, honest, and reliable of citizens, the doctor of medicine, now acted, to an extent, in reverse. Once more we were in some respects carefree students; we even had our class "cut-up", a little creaky in the joints, it is true, but ever ready to make the appropriate wise-crack.

Any doubts which still existed as to the value of this course were completely dispelled that first morning; it was clear from the programme that the subject matter, and speakers, were to be of the highest calibre. Perhaps here it may be said that at the conclusion of the course, we were agreed that few of us had ever taken part in any course of instruction which so consistently maintained such a high standard throughout. This represented a wide field of experience, for there were physicians at the course from a very complete range of medical activities, including general practice, public health, the Armed Forces, and industry. This, too, gave added value in the discussions since, though industry was very strongly represented with the presence of some 18 medical directors and officers from many of the leading industries and public utilities, there were other points of view to be considered and correlated in the overall picture.

A. B. C. Warfare:

"In the event of enemy attack on a Canadian community, our first thought must be to rescue the living, care for the injured, and bury the dead. These functions cannot be left to blind chance or to emergency eleventh hour planning. Without proper advance organization, a community would suffer unnecessary casualties through the lack of voluntary health workers, the shortage of planned emergency hospital accommodation and the inability of professionally-trained health personnel to co-ordinate their efforts in the confusion that would inevitably follow an attack.

The development of thermonuclear weapons, with all their unimaginable potential for destruction, serves only to accentuate the importance of the physician and of health workers generally in civil defence planning. The H-Bomb has altered our thinking in many particulars of detail but it has also served to re-emphasize the urgent need for well-organized, flexible and carefully thought out health services."

These words, taken from the address of welcome given by the Minister of Health, the Honourable Paul Martin, very succinctly summarized the extent and purpose of the course. In the days to follow, the ultimate enormity of the thermonuclear weapons hung like an indefinable pall over the proceedings, engendering a feeling of urgency and determination.

The first two days of instruction were devoted largely to a consideration of the newer types of weapons of "Mass Destruction", and chemical and bacteriological warfare. More specifically, of course, the medical aspects were highlighted, and to many, the immediate, and more remote, effects of radiation were a new concept. The recent report by the U.S. Atomic Energy Commission on the Effects of Highyield Nuclear Explosions was timely and added much to the deliberations. Naturally, of course, the problem of "Fallout" assumed a high place. It was encouraging to learn that many, very simple, precautions such as shelter,—even minimal— avoiding exposed foods, and bathing and changing of clothes, do much to considerably diminish the dangers from radiation. Many types of simple radiation detection instruments are being developed, some of which were demonstrated.

Although perhaps less dramatic and "massive" in action, the gases, particularly the new nerve gases appear sinister and likely to pose their own problems. As surprise is a "must" for the successful use of gas warfare, it is considered that the most likely chemicals to be used would be the nerve gases. The rapidity of action of these nerve gases needs especial attention in Civil Defence training; the importance of the first level of treatment—self-help—cannot be over-emphasized.

Biological warfare has exercised the popular imagination for many years. The potentialities of "germ" war have been explored extensively in the lay press and more lurid magazines. It is probable, in fact, that the opportunities for this type of warfare would be of a limited nature. However, as was shown in this course, a saboteur could cause a considerable amount of disruption and havoc by, for example, contaminating a large city's water system. The number of biological agents capable of use in this field are themselves limited, but the potentialities of such a substance as the toxin of botulinus needs no elaboration. The physician, by alertness, can recognize the presence of an unusual disease,—or changed pattern or trend of infection,—and thus play an important role in this sphere of civil defence. Immunization procedures need consideration, and will be another duty of the physician.

Clinical Considerations

In additon to lectures on the treatment and prevention of radiation sickness, and the other manifestations caused by these newer weapons, some time was

devoted to the consideration of what might be termed more "orthodox" medicine. Here many of the class felt themselves to be on much firmer and more familiar ground. As a passing thought on these lectures, it was interesting to note, once again, that surgeons are characterized by clear thinking and decisive delivery. This must be in keeping with their particular field of practice.

It was made clear that in times of emergency all must be prepared to carry out their various medical functions with very much less to work with than they are at present accustomed. However, it is something which requires acclimatization, for under modern conditions, it may not be easy: To forget the refinements of sterile surroundings for operations; to be prepared to operate on a patient who is not at the "peak" of pre-operative conditions; or to fall back on "the rag and bottle" as used by the earlier anaesthetists. These are factors which will have to be faced and accepted, for undoubtedly situations may arise when the physician will have to carry on as best he can, in far from ideal surroundings.

Another interesting sidelight on the clinical lectures, was the fact that much of medicine proceeds in fashions. In this respect the simple, explicit advice on the first treatment of burns and fractures illustrated the return in thinking to basic first principles. It was felt that the problem of triage was dismissed a little too easily. Under disaster circumstances, the condition of a casuality is very often one of the most difficult things to assess and requires considerable experience.

In concluding this section on the clinical aspects of civil defence, it is essential that a word should be said on the lecture on "Psychological and Psychiatric Phenomena in Catastrophe". This was an outstanding contribution, carefully considered, and most clearly given. The reactions, and the reasons for such reactions of individuals and crowds had been most minutely studied and analyzed. Much of the matter was not, strictly speaking, "new" but few can have heard a more explicit account, or a more sound application of common sense.

Organization and Administration

It is not proposed here, to attempt to outline the organizational detail in civil defence health planning, which was the subject of several lectures and discussions during the course. A few notes on certain aspects may, perhaps, be in order.

There can be no doubt that the potentialities of the H-Bomb has, perforce, altered the thinking on civil defence planning. It is clear that now there can be no rigid plans. All plans for civil defence must be flexible, and mobile, in order to be able to function to the best advantage under all circumstances. In long term considerations, it would appear that wide decentralization of industries should be given high priority in order that productivity, vital to the country, can continue in the event of war. For, as was constantly stressed during the course, evacuation, partial or perhaps even complete, of some large cities might have to be considered. Particularly in the field of public health this propounds enormous problems at all stages of evacuation—in the city, along the various exit routes, and in reception areas. Several of the class remembered the many difficulties which had to be overcome by the E.M.S. in the comparatively "simple" task of evacuating selected hospital cases from London, England, in the early stages of World War II, and that under relatively ideal and uncomplicated circumstances.

The need for leadership in the development of local plans is very great, and in this respect it was shown that industry can do much to give that lead. Many of the larger industrial firms today have comprehensive health services; they are disciplined, "enclosed", organizations which could very easily be placed on a disaster footing. Undoubtedly industrial medicine has an important role to play in the overall plan for civil defence health services, and may be of especial importance in local civil disasters.

'Live' Demonstrations

Earlier it was mentioned that there were two other courses in operation at Arnprior concurrently with the one under discussion. These were Casualty Simulation and Rescue.

Casualty simulation is a comparatively new,—and most effective,—technique to aid in First Aid teaching and in the acclimatization of the layman to casualties. It is a method which must have had its conception in the ketchup "blood" of the stage. By many of the physicians who had not previously seen this work, it was enthusiastically acclaimed as a very real advance in instructional methods.

On the final night of the course a demonstration of rescue work took place. This was carried out by members of these two courses, and witnessed by the doctors. It proved to be most actualistic, practical, and thought provoking. The exercise was started by the siren alert, and no one who has heard, under wartime conditions, the rising and falling banshee cry of an "Alert", filled with urgent foreboding, can ever again listen to it with complete equanimity. From this realistic beginning, the exercises proceeded, with the rescue workers extracting "casualties" from the debris of destroyed buildings, and then transporting them to first aid posts. A high standard of efficiency by these trainees marked the performance of this very strenuous work. This is but a "thumbnail" sketch of a most successful and very worthwhile demonstration.

(concluded on page 16)

By Morris Grayson, M.D., F.A.P.A.
Assistant Professor of Clinical Psychiatry, New York University

It will be my intention in this brief discussion to summarize for you part of a study which I had the honour to conduct July 1948 to September 1951. The findings of this study were subsequently further explored under my direction from 1951 to 1953 and are still being studied by my colleagues.

In 1948 we undertook to explore what appeared to be a relatively simple problem. We were interested in learning something about motivation. Specifically, in relation to physically handicapped individuals, we were interested in finding out why some physically handicapped individuals can be rehabilitated and others not.

The personnel involved in this study consisted of a psychiatrist, a clinical psychologist and a psychiatric social worker. That was the nucleus of the team but also bringing observations to us was a group of medical specialists: neurologists, orthopedists, industrial physicians, internists, physiatrists, as well as physiotherapists, nurses and aides.

Foremost in this whole team was the patient himself. We saw the patient frequently, we tested him thoroughly and we observed him carefully. Amongst these physically disabled individuals were paraplegics, and those disabled by the neurological and rheumatoid diseases and by direct trauma.

In our study, approximately 86% of our disabled population showed some form of emotional disturbances which interfered radically with their full rehabilitation. In other words only 14% were capable of integrating their problems to a point where they were capable of utilizing the services of our Institute to their maximum and could be rehabilitated. A good percentage of the other 86% were rehabilitated only after a reorganization of our approach so that the emotional problems were foremost and primarily attacked.

I will forego the questionable temptation to evaluate the true meaning of these figures. A question you are bound to pose will be, "what were your criteria of rehabilitation?" or, "what sampling process did you use?" etc. etc. I should thus prefer to examine some of the more qualitative aspects of this problem and assume that a physically disabled individual is bound to have emotional problems.

More precisely, I believe it more profitable to evaluate some of the more general and specific problems which the practitioner will encounter in the rehabilitation of the physically handicapped and which are directly related to the field of psychology and psycho-pathology.

For the most part the psychology of the physically disabled does not differ radically from the psychology of normal people or the psychopathology of normal people. The process of regression to childlike behaviour or the appearance of psychoneurotic behaviour, or even psychoses is not the special province of the physically disabled.

To summarize the qualitative aspects of our findings, we found in general that:

1. It was impossible to predict the degree of rehabilitation on the basis of the physical disability alone.
2. The pre-morbid personality played by far the greatest role in the process of rehabilitation.
3. The personalities and attitudes of the rehabilitation personnel play an important role in rehabilitation.

Now let me outline the reasoning behind these conclusions.

I. It was impossible to predict the degree of rehabilitation on the basis of the physical disability alone:

This conclusion was self-evident from the start. While it is true that there are many disabling illnesses which are overwhelming physically and mentally, we were constantly faced with pictures of extremely disabled individuals (quadriplegics for example) who make not only an excellent adjustment to their disability but are frequently self-employed and vocationally productive. On the other hand, it is not uncommon for us to see individuals with minimal disability (a swollen or painful hand) find it impossible to go to work and become chronic invalids.

2. The pre-morbid personality played by far the greatest role in the process of rehabilitation:

*Presented at the Joint Meeting of the Industrial Section of the Ontario Medical Association and the Quebec Industrial Medical Association, September 1954 in Ottawa, Ontario.

The great variability in reaction to similar disabilities led us to probe the personality structure of the individual. It was not uncommon for us to be confronted with fears and anxieties which existed long before the disability occurred. Superficial examination would elicit complaints primarily in connection with the disability but in going beyond the superficial aspects, a multitude of complaints and attitudes would evolve which stemmed from very early in life's experiences. The attitudes ranged from attitudes toward work, toward one's body, toward interpersonal relationships. In other words, patterns laid down in early life were rarely changed by a disability.

Some idea of these early attitudes and some clue as to the configuration of these early experiences can be gotten from some of the statements of disabled individuals.

(a) "Nobody loves a cripple. I couldn't look at them when I was a kid, why should people care for me."
(b) "If you had a painful back like I do, you wouldn't be working either."
(c) "People don't expect too much from you when you are crippled."
(d) "This solved a lot of problems for me."
(e) "I've learned to live with this pain. I don't know what I'd do without it. It's gotten to be a friend of mine."

Further investigation led us to the conclusion that somewhere in the life experience of the individual an anlage for one's attitude toward disability has been laid down. This is not a new concept. Some have explained this in part by the concept of the body image, others prefer to attribute this kernel of later anxiety to an unresolved castration complex. Just which concept provides the true analysis will be neglected at this time. Both inform us of the role played by early patterning.

An operative approach to the understanding of this early patterning as well as an understanding of the present chaotic responses of the disabled individual can be obtained from the concept of defence mechanisms.

We understand this concept of defense mechanisms as follows:

When an individual is hit or hurt in some way, he automatically sets up a series of defenses. 1. Against further injury. 2. Against a real inferiority or an apparent inferiority. In the course of setting up these defenses, the apparent inferiorities may loom larger than they actually are and as a result the defenses which are brought into play may be more disease producing than the illness. Some of the defenses commonly encountered are 1. Overcompensation 2. Regression (invalidism) 3. Flight from reality 4. Substitution.

Of these four, the last, substitution, is the least troublesome. The overcompensating defense is usually a welcome defence but may at times prove troublesome, especially when the inferiority is physical and the overcompensating is of a psychic nature and there is no real substance to the compensating process. The defense of invalidism is also well known. It may take many forms, chief amongst which is a psychic regression where the individual becomes passive and dependent on his environment. Flight from reality as a defense may also take many forms where the individual may actually deny a physical defect or may insist on a vocation ignoring the defect.

I've used the term "troublesome" or "welcome" in relation to these psychic defences. These adjectives are used primarily from the point of view of the rehabilitation personnel or society. Occasionally the defenses meet the purpose they set out to accomplish but occasionally, they interfere radically with the rehabilitation process which strives to keep the individual as close to reality as possible.

3. The personalities and attitudes of the rehabilitation personnel play an important role in rehabilitation: What has preceded is of course not the whole picture. The process of rehabilitation involves many disciplines. All of you can certainly testify to successes where others have failed. I am sure that patients have been rehabilitated where you have failed. It certainly is not dependent upon your knowledge or your lack of knowledge. The workers in rehabilitation play a role not only by their physiotherapeutic approaches but by their own personalities. This can be readily understood if we realize that any illness, any disability, has a tendency to make the individual get closer to himself. The individual becomes more conscious of his personal physical functioning than at any other time. Hands, as such, which may have been taken for granted, suddenly when they are disabled become objects of study and one is conscious of them. The same of course holds true for legs, the heart, the pulse, the vertebral column, etc. In this process, a sort of regression takes place and the individual's reaction to his body is more the reaction of a child rather than an adult. With the attitudes toward the body goes a similar attitude toward the people in the environment. Thus what the physician says and how he acts in relation to the patient plays an important role. Frequently the persistent optimism of a physican in the fact of marked disability gives the patient courage to go on in spite of his depression and "give-up" feeling.

This is just a summary of some of the observations we made. It is by far not the whole story of the psychiatric aspects of rehabilitation of the physically disabled. We had opportunities to study specific fears, specific anxieties in relationship to specific illnesses. In conclusion, I should like to suggest to you, when

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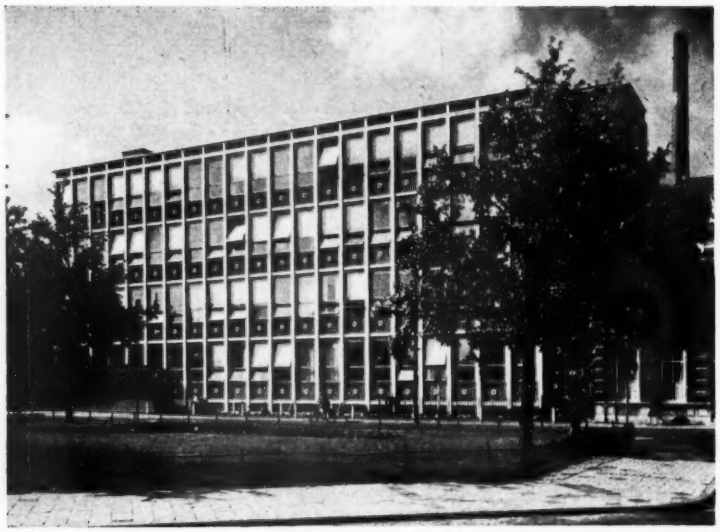


the PHILIPS HEALTH CENTRE*

The visitor to Eindhoven, Holland, cannot fail to be impressed by what reminds him of the life and work of Dr. Anton Philips. There is the statue, perpetuating his memory. There are the gigantic factories breathing their tribute to his dynamism. There are schools, sports grounds and a recreation building, testifying to his interest in welfare. And now there has been added yet another monument in recognition of his humane feelings—the Philips Health Centre.

The stylish grey building is a proof of the high regard in which the Board of Management hold medical care for the personnel. But it is also the realization of an industrial physician's dream, the realization of an ingenious scheme for the best possible medical care designed by Prof. Dr. G. C. E. Burger, Medical Director of the Philips Health Centre.

The sober, modern interior and the efficient layout of this new poly-clinic are exemplary. They offer to executives and personnel of the medical department, the sick fund, the sick benefit service and the labour protection department—all centralized in this one building—ideal circumstances for serving the concern and its members to the best of their mutual and individual interests. Offices, consulting rooms, laboratories, therapy departments, X-ray departments and dark rooms, were all made with a view to maximum medical efficiency. Ultra-modern equipment, an ample library and other facilities aid the physicians in their job.

But the Philips Health Centre could not have been such a smooth working and many-sided operation with these aids alone. Without a good team of physicians, it would have been little more than a beautiful, empty showplace. The main advantage of the Health Centre lies in the centralization of the various sections and the way in which mutual co-operation and assistance among them are promoted.

The Medical Department can be said to consist of the three main services—industrial medicine, curative medicine and medical supervision of claims to the social insurance funds. In order to explain something of what is done medically for Philips personnel in and around Eindhoven, it is necessary to describe in brief outlines the scope of each of these sections.

Industrial Medicine

Before entering the service of our concern, every worker passes through the hands of the Industrial Medical Service under Dr. G. J. Fortuin. This is when he or she is subjected to a medical examination. Pre-employment examinations are known to give rise to the supposition that only the fittest people are engaged and all others rejected. Nothing could be less true. The main aim of this examination is to establish the sort of work for which the worker is best suited, mentally as well as physically. And this, as will be clear, is advantageous both to the worker and to the concern.

Industrial medicine, however, does more. The annual compulsory mass screening of the entire personnel keeps a check on lung and heart diseases. This periodical X-ray examination has now been taken over entirely by the Philips Chest Clinic. Great importance is, however, to be attached to the fact that the head of this clinic has first acquired years of experience as a works medical officer and is quite familiar with the problems of industrial medicine.

The backbone of this medical service is formed by the works medical consulting hour and the factory supervision associated with it. This consulting hour is

*Reprinted with permission from the May 1953 issue of the Announcer, Monthly Review of the Philips Industries, Eindhoven, Holland.

entirely devoted to preventive and social-medical work. The placing and transfer of workers, difficulties arising on the job, either on the part of the worker or of the management, judgment of a person's suitability for a particular job and of the rate of working, all these problems call for knowledge of the industry as well as knowledge of the state of health of the worker.

Other activities of the industrial medical service are the periodical examination of those workers who are exposed to toxicological or radiation hazards and the supervision of working environments. In co-operation with the pharmaceutical service, toxicological prevention is promoted.

Clinical medicine together with the knowledge of labour hygienics and labour physiology forms the solid foundation on which the works medical officer has to base his advice.

The Eindhoven works are divided into sectors and a medical officer has been appointed to each one of them to carry out the work of industrial medicine to its full extent. Certain matters of particular importance are further dealt with by one particular medical officer. For instance, one deals with measures concerning lighting and atmosphere, another with statistics and so on.

As the works medical officer directs his attention to the human being in relation to his work, both as an individual and as a member of a group, there are numerous points of contact with technical engineering and many problems lie half way between technical and medical services.

Curative Medicine

The Service for Curative Medicine under Dr. van Alphen de Veer is popularly called the family doctor's service. Both names speak for themselves. The organization of this section, however, is quite different from what is usual both in Holland and abroad. Here, we have a group of full time doctors working under the guidance of a physician. Members of the general sick fund are free to choose as their family doctor any of the eleven physicians listed under the family doctor's service. Once a year there is an opportunity to alter this choice, but very few people make use of this opportunity.

Every physician gives medical attention to an average of about 4000 persons. This may seem to be a large number but the family doctor is always assured of the support of an extensive organization. His task is made lighter both by material assistance and by help from auxiliary personnel and experts.

Working with a group of physicians, in close co-operation with others, practising in all sorts of different fields, and provided with every means for examination, treatment and administration, the family doctor can follow his profession with scientific interest in the broad-

Tiled Corridor gives impression of the interior of the building.

Butterfly bath for rehabilitation purposes.

est sense, in spite of increasing specialization. By working in a group it is possible to co-operate organically, to make and carry out arrangements for the furtherance of proper medical treatment.

In Philips medical department, there is a trend towards associating the family doctors with the preventive side of medical practice, for instance by entrusting to them the further examination of such patients as appear to be in need of it as a result of the periodical general examination of employees. Further, the family doctor service undertakes the immunization of all children against smallpox, whooping cough and diphtheria. There is close co-operation between the works medical officers and the family doctors, particularly in matters concerning the rehabilitation of convalescents and changing of jobs for reasons of health.

Claim Supervising Physicians

Last but not least comes the work of the claim supervising physicians, whose duties may best be defined as the rendering of advisory reports, based on their own medical examinations, as to the validity of claims entered by insured persons against social institutions. As far as our sick benefit service is concerned, this means the exercising of control over absence through sickness in the best interests of the individual and the community.

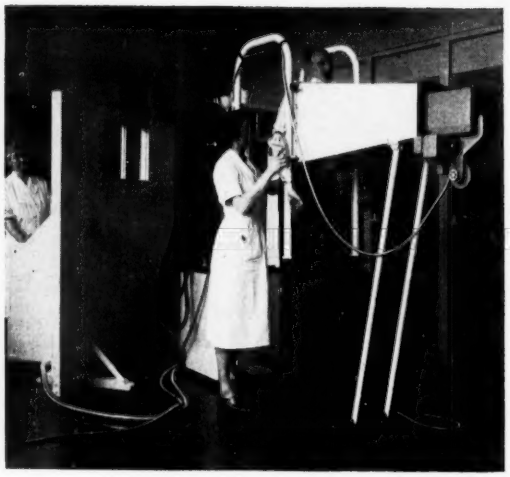
The claim supervising physician does not treat a case himself but consults with the attending physician about the treatment, if that tends towards a better result in regard to recovery. From this it follows that prevention has to be one of the foundations on which the supervising function is to be based; the team work in the medical group creates many possibilities in that direction. Moreover, the numerous facilities of our health centre enable the supervising physician to carry out an extensive examination, often supplementing that of the attending physician.

This particularly applies in the case of patients who are not being attended by the company's staff of medical practitioners, such as patients living outside Eindhoven or those undergoing specialist treatment.

Naturally the attending doctor is always informed of the results of such examinations.

There is More

These three services (preventive, curative and supervisory) are the three pillars upon which the Philips Health Centre is built. They do not, however, cover all the different aspects of medical science which occur in a complex and sizable industry like Philips. It is one of the indubitable merits of the management of the medical department and particularly of Prof. Dr. G. C. E. Burger, Medical Director, that—often by making use of specific interests among the physicians for particular facets of medicine— many sectors of medical science are covered.



X-ray equipment.

Knowledge gained as to the effect which psychological factors have upon illness and absenteeism induced Dr. van Alphen de Veer, the chief physician of the family doctor's service, to make an intensive study of this subject, with the result that all the physicians are now taking a keener interest in medical psychological problems and psycho-somatic illnesses. A consulting bureau for medical psychology has now been established.

The treatment at home of patients suffering from thrombosis in its early stages led to special measures being taken under the responsibility of a family doctor by means of which a satisfactory result is to be attained through co-operation between the attending physician and the laboratory.

The testing of X-ray apparatus produced in our plants, the medical aspects of illumination and of welding, have all been subjects of studies by physicians and have resulted in improvements being made in medical and industrial-medical techniques. These studies have also resulted in manufacture improvements for X-ray apparatus and welding electrodes and in illumination devices.

From these examples it is evident that the growth of the medical department has been such as to derive the fullest possible benefits from the advantages that are to be realized from working in groups.

Some other branches have to be mentioned. The department for physio-therapy and massage is a valuable section for the treatment of illness and accident cases. This Department is growing more and more in the direction of rehabilitation.

A specialist in internal diseases and a gynaecologist-obstetrician, both from the ranks of the family

doctors, are working in the curative group; as advisers respectively for the laboratory and the obstetrical service they also take a direct part in the group's work; they have their consulting hours in the Health Centre. In addition to these specialists, there are also the chest specialists attached to the chest clinic, and the radiologist. The latter first entered the company's medical service as an accident doctor and subsequently specialized in radiology. He now combines both these functions. This again is an example of the development determined by the needs of the service and the interest taken by the physicians in their duties.

The existing contact between the medical officers and the works management provides a medical labour analysis which is of value in the solving of a number of problems relating to industrial medicine. From such activities as these there has sprung up an organization which could best be described as the clinic for handicapped workers dealing with cases where a person's fitness for work is limited, either through illness or on account of old age. The technical functionary of this bureau may be said to perform a function similar to that of the tuberculosis inspector working under the chest clinic, since the organization and methods of working are, in principle, the same for both these bureaux.

An institution has been created for heart investigation, with the aid of modern appliances. This work is facilitated by cardiographs and other electro-medical equipment which is manufactured by the medical apparatus division.

When it became necessary to get a better insight into the functioning of the respiratory organs, one of the medical officers was charged with the functional respiratory examination of all cases requiring this examination.

Industrial accidents are dealt with by a medical service duly recognized under the provisions of the Netherlands Accidents Act of 1921. This means that the majority of accidents can be dealt with by the service and need not be reported to the State Insurance Service. A considerable saving in administration expenses and also in decreased loss of working hours is thus effected. For the treatment of minor injuries in the works several first aid posts have been set up. Medical treatment is given here by Philips people who have followed a first aid course in their spare time. Central emergency stations are manned by male nurses. These first aid posts are dotted about the factory area and are used for the treatment of minor accidents. More serious cases are sent on to the Health Centre or, if necessary, to a hospital.

The organization for treatment of industrial accidents is efficient and offers quick help to injured workers.

In the field of nutrition, every attention is being paid to correct dieting. Two qualified dieticians are available for working out diets in accordance with the family doctor's directions and to see that these diets are strictly followed. These dieticians also carry out, and analyse the results of, enquiries into the feeding of various groups of workers and organize propaganda for good feeding rules.

The advantage of team work becomes most apparent when turning to the problem of collecting the statistics on the loss of working hours through illness. Thanks to the intensive co-operation practised between attending physicians and the works medical officers it has become possible to collect statistics of absenteeism through illness which have proved to be of value not only to our own industry but also to others.

Numerous other facilities are available to the family doctors within the scope of the company's own service. Advanced polyclinical work, such as metabolism tests and examination of kidneys and the stomach is being carried out regularly and greatly reduces the necessity of clinical observation.

Dental treatment of Philips people comes under the provisions of the sick fund. Under the rules and regulations of the sick fund's decree, preventive dentistry is promoted by issuing cards to all insured people, entitling them to a dental examination and preservative treatment at regular intervals.

One of the most recent additions to the general scope of the medical department is the Health Education Service. One of the family doctors has been charged with the task of increasing health consciousness among Philips workers. It is hoped that this education will contribute to the prevention of illness by improving in a medical and hygienic sense the worker's mode of living—often a cause of susceptibility to illness.

To ensure that close contact is maintained between all classes of physicians, weekly meetings are held to discuss organizational matters, to decide incidental measures concerning certain problems, to discuss the current figures on absenteeism and, in fact, to conduct all such discussions as may be necessary to promote co-operation.

Furthermore, there is a weekly meeting of the works medical officers at Eindhoven where all problems of industrial medicine and hygiene are discussed. Scientific activities are stimulated by lectures and discussions on important matters from medical literature.

Probably only few of the more than seven hundred people who visit the Philips Health Centre daily for medical treatment realize how exceptional the organization of the medical department is. And this organization today is in a way the fruit of the decision taken in 1940 when all the different sections of the medical department were brought under single management

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CONFERENCE - BRITISH OCCUPATIONAL HYGIENE SOCIETY

THE ASSESSMENT OF HEALTH AND DISEASE IN INDUSTRY*

The fourth conference of the British Occupational Hygiene Society, dealing with the above subject, was held at the London School of Hygiene and Tropical Medicine on 4th April, 1955. The President, Dr. J. M. Rogan, occupied the chair.

Dr. Donald Stewart, Chief Medical Officer of the Austin Motor company, read the first paper. He defined occupational health as the application of medical knowledge to the employment circumstances of the individual which affect his physical and mental well-being. A unique opportunity to promote health was offered to those who managed industry and it was vitally important that technical and medical advice of high quality should be available for them. Legislation in this field had a far-reaching effect and should be carefully planned.

Occupational health extends far beyond curative medicine and must enlist the aid of experts in engineering, toxicology, chemistry, etc., but wide problems of clinical medicine are still important in industry, and concern with environmental and epidemiological studies alone is inadequate.

Illness due to toxic substances, disabilities arising from accidents, psychiatric disturbances associated with occupation and aggravation of disease processes by work demands are all familiar to the industrial practitioner. Another aspect of the clinician's work is concerned with placement; many disabled workers are effective producers in the right job. Work study is a natural corollary to clinical assessment of capacity and may also reveal toxic or physiological hazards. An opportunity exists for adapting present-day techniques of job analysis to the requirements of workers in the field of occupational hygiene and medicine.

Aids to the assessment of health in industry included the provision of machinery for carrying out investigations, the availability of expert advice and the provision of an information service. The respective responsibilities of Government Departments, Universities, research bodies and of industry itself need to be thought out with these problems in mind.

Most of the discussion on Dr. Stewart's paper centred round the provision of ancillary services, such as X-ray, dust counting and chemical analysis, upon which the industrial doctor could draw. Help which had been given in certain cases by the Public Health Laboratory Service, the Factory Department and the Medical Research Council was mentioned, and it was suggested that the Public Analyst might extend their work beyond the analysis of water and food to include estimation of toxic substances. In reply, Dr. Stewart said he thought that the country could not afford to have such investigations carried out at the public expense and that industry should pay for them, and would be willing to do so if proper arrangements were made; a lead should be given here by the Ministry of Labour.

The next paper, by Dr. R. Murray, H.M. Medical Inspector of Factories, Manchester, dealt with the medical work of the Factory Department.

The Department worked through its Medical Inspectors whose duties included investigations of industrial disease, the supervision of Appointed Factory Doctors and liaison with factory medical officers and others concerned with occupational health. The Appointed Factory Doctors were general practitioners

*This summary was prepared and submitted by C. N. Davies, D.Sc., F.Inst.P., Hon. Editor of Transactions, London School of Hygiene, London, England.

who carried out statutory medical examinations of young persons and periodic examination of workers exposed to special hazards; they also reported cases of notifiable industrial diseases and of gassing.

In the ensuing discussion tribute was paid to the work of the non-medical inspectors—chemical, engineering and electrical. Out of a total of 400 inspectors only 13 were medical; the number of factories served was about a quarter of a million. The industrial nurse also occupied an important position and in many factories there was only a nurse with no full-time medical officer. Concerning the notification of certain diseases, attention was drawn to the unnecessary duplication which resulted from the definition of both notifiable and prescribed diseases; the necessity of ensuring that the employer should be aware of his responsibilities in the matter was mentioned.

The third paper was presented by Dr. R. McL. Archibald, Medical Officer, North-Eastern Division, National Coal Board. Considering health, he emphasized that the pre-employment medical examination should be related to the industry which it served. A standard which would be perfectly satisfactory for light work might not be good enough in heavy industry. Productive occupation for rejects from occupations involving severe stress must be sought for in work making smaller physical demands. There was an enormous variation from the normal, within the range of physical fitness. The medical examination should be directed towards finding the most suitable job for the applicant, with regard to his physical capacity, not to the elimination of persons unlikely to be able to fill a particular post.

Dr. Archibald mentioned many important practical aspects of the work of the industrial medical officer. These included his place in pilot experiments with new substances, the need for prompt evaluation of hazards, the importance of familiarity with men, management and plant, the keeping of records and collaboration with engineers and scientists. The problems that had to be dealt with were usually quite mundane and research should be conceived with this in mind.

Points raised in the discussion included the position of the industrial medical officer in relation to general practitioners. When the factory medical department was closed the worker had to go to the latter who also had the advantage of being backed by the hospital service. The workers might tend to use their general practitioners on all occasions. The works medical officer had to provide, with the help of his management, an effective service which would encourage his cases to come to him; if he provided himself with technical assistance it would enable him to carry out his investigations more satisfactorily.

The necessity of observing the effect of standards in pre-employment medical examinations was emphasized; it would not do to exclude a large section of the population from industry.

The final speaker was Professor A. Bradford Hill, F.R.S., of the Department of Medical Statistics and Epidemiology, London School of Hygiene and Tropical Medicine. He spoke of the relationship between the deaths of men employed in different ways and the number of men so employed as revealed by the analysis of death certificates and of the census. Such statistics require cautious interpretation—for instance, a relatively high death rate in a light occupation may only mean that the physically unfit are attracted to it. Again, the death certificate records the occupation followed at the time of death, whereas the cause of death may be associated with an earlier occupation. The mortality of wives of men engaged in different occupations is also recorded on the death certificates of the latter, so some separation of specific occupational influence from that of general environment is possible. These routinely collected mortality statistics are unlikely to solve problems, but they do, at least, bring them to notice and promote research.

The measurement of sickness incidence raises still more difficulties. Defining it as 'incapacity to work' brings into the recorded rate not only pathological conditions, but many other social, administrative and economic factors which influence the rate of incidence and complicate comparison within and between industries. The aim of sickness recording in occupational hygiene is to promote the development of preventive measures. It is doubtful if a national system would give worth-while returns for the heavy work of collection and analysis.

Analagous experiences in measuring health and disease in the coal industry were mentioned in the discussion. The vast majority of miners with massive fibrosis of the lungs died outside the industry; another disadvantage of using death as an index of occupational hazard was the number of diseases, particularly the rheumatic ones, which did not kill. Absenteeism was a possible index for which exact figures were available, but at present they were quite impossible to interpret. This was being investigated by the National Coal Board. It seemed probable that the only place in which health could be measured in relation to an industry was not in the industry itself, but in the industrial community. One of the main difficulties here was in getting a reproducible lower limit to the various diseases.

A more complete account of the Conference is being published in the British Journal of Industrial Medicine.

Editor's Note

We are very pleased and privileged to have the opportunity to publish the foregoing material. It most ably shows the excellence and high calibre of the work

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The Contribution of the NURSING CONSULTANT in the development of OCCUPATIONAL HEALTH NURSING*

Miss. Mildren I. Walker, Nursing Consultant, Occupational Health Division.

It is indeed a privilege to discuss the Contribution of The Nursing Consultant with those who are giving nursing services to people at their places of work. The nurse in the plant health service is the key person who is at the central or focal point of the total service. Through good nursing on the job, and by her interpretation of that service she has won a place in industrial relations which is considered essential and which we believe is here to stay. The plant nurse then is in a strategic spot to interpret and promote better health service while at the same time assuming responsibility as a member of the Nursing profession to conserve nursing which is a scarce commodity in the employment market. The best means to accomplish these will be to develop a shared responsibility for nursing in Occupational Health with the nursing consultant. The purpose of this discussion is to enumerate the contributions of the nursing consultant in occupational health and to indicate the satisfactions which as nurses in the field we may expect as outcomes. To deal adequately with the broad topic under discussion it is necessary to consider the place to begin in our thinking and to set certain limits.

In situational thinking (1) there are two approaches which can be made. There is "person centred" thinking, and "policy-centred" thinking. In the first, the emphasis is on the personal or the human element; in the second on an understanding of the general principles that apply to the human situation associated with the mechanical elements involved. Each approach is important and one must not be sacrificed for the other. As an example, the nursing care of a critically injured employee in the industrial health centre is "person-centred"; consideration of the case in the industrial relations program of the company is "policy-centred". It is for the nurse to decide which approach she uses and when.

The approach of the nursing consultant is "policy-centred" with assistance being provided in principle and applied to the particular group or industry in a specific situation. From the Federal Nursing Consultant's position in Canada, this approach is consistent with the relationship of federal and provincial health departments. Under the British North America Act, such programs as health, education and highways are provincial responsibilities and assistance provided by federal departments is on request from the provincial department who may accept, modify, or reject any suggested solutions which are offered. The "policy-centred" approach also permits an objective appraisal of the Nursing Consultant's program without becoming involved with personal factors.

The Role of a Consultant

The rapid increase in scientific developments over the past few decades has rendered it impossible for one person to accumulate all the knowledge and be an expert in all aspects of his field of endeavour. Consequently, it has been necessary to limit the scope of study to more specific areas in order that the individual may gain a more complete knowledge of a small portion of the total picture. Such an individual is referred to as a specialist in his own particular line and if he is sufficiently well-versed, his services are likely to be sought by other individuals or groups for assistance in the solution of problems in this area. He will study the problem, make an objective appraisal, and offer con-

*Adapted for publication from a paper presented by Miss Walker at New York University, March, 1955.

structive suggestions for solution based on his advanced preparation and experience. The recommendations of this specialist may be accepted in toto, modified, or rejected. In this context, the specialist is assuming the role of a consultant.

In general, a good consultant makes his services progressively less necessary, because he helps people to help themselves, and in so doing increases their self-dependence. He promotes success. In order to be successful in this respect, the consultant must accept himself as a person with special accomplishments, which should be used in every possible way to further understanding among individuals and stimulate the growth of the field he serves.

The Nursing Consultant in Occupational Health

The role of the Nursing Consultant in Occupational Health is comparable to that of a consultant in any other field, in that her services are given, on request, to industries and other organizations who desire information and guidance on occupational health nursing. At no time can she be autocratic because her service is consultative, designed to provide as much assistance as possible without in any way interfering with the executive or production aspects of the organization.

In large industries, where there is a medical department employing a number of nurses, the role of the nurse in the senior position may be considered as consultative in nature—she is in a position to assess the function of each of her staff in relation to the total health service and she will interpret to a large extent the functions of the nursing staff and their service to management. She will use the "policy-centred" approach in her administration. Although she is in a senior capacity she also shares the responsibility with the nurses on her staff to provide the best possible nursing service. This is known as the "consultative-participative" relationship and will be discussed later.

Contributions of the Nursing Consultant to Occupational Health Services

As was stated earlier, when an industry has a problem on which specialized knowledge is required, a consultant is frequently called in. Similarly, the services of the nursing consultant are requested as the industrial nurse, physician or management sees the need.

The Government Nursing Consultant, with her knowledge of the total situation of Occupational Health in the province, or the whole country as the case may be, can help the nurse to understand how consultant service may assist her in the further development of the industry's health program. This is realized as the Nursing Consultant develops her public relations programs and is further augmented by visits to industries, meetings, conferences, contributions to scientific literature, and research on industrial problems at the request of nurses, doctors, or members of management in industry.

Through the medium of the various publications, the senior Nursing Consultant of the Occupational Health Division, Department of National Health and Welfare, has made a considerable number of contributions to the field of Occupational Health Nursing. For example, an article entitled "Spotlight on the Health Centre" (Occ. Health Bulletin, Jan. 1953, and Occ. Health Review, March 1953) was written as an answer to a request from industrial nurses for information on the setting up of a new health centre; in another instance, "A Consideration of Basic Personnel Policies for Industrial Nurses" (Occ. Health Review, Vol. 2, No. 2, October 1950) resulted from the fact that nurses were having difficulties arising out of their own employment relations; suggestions for a standardization of the name for medical or health services in industry stimulated the preparation of "What's in a Name" (Occupational Health Bulletin, Nov. 1952); "Orientation Program for Industrial Nurses" was written by the Federal Nursing Consultant and incorporated into the Orientation brochure of the Canadian Nurses Association.

The Nursing Consultant frequently receives requests for information and service from members of management and industrial physicians. One such request was as follows: "If we appoint a nurse, what are the services we should expect in our industry?" The information supplied was drawn from the article "Scope of Medical Services in Industry", which was outlined by the Occupational Health Division, Dept. of Nat. Health & Welfare, and published in the Occupational Health Review, Vol. 3. No. 1, December 1951. Recently, a nurse wrote for suggestions concerning the reorganization of the employee health service in a large hospital.

Knowledge of Current Practices and Trends

In addition to her role as an adviser the Nursing Consultant considers her visits to an occupational health service as a learning experience. She learns how each industry interprets its Health Service in relation to the principles of occupational health which are applied to its individual situation. Every service has a common objective which is the conservation of the health of employees, but each must be tailored and applied to meet the needs of the particular plant. Each service also reflects the influence of the nurse in charge, and the consultant applies her knowledge of social climates to understand the "feelings" expressed in the atmosphere of each health service. The situation will reflect the opinions and personality both of the nurse and of the company management. Another important feature in the program of the nursing consultant is an understanding of trends in nursing, medicine, management practices, industrial relations and personnel administration.

Objectivity

When making an appraisal the consultant must be aware of the emotional influences and pressures which exist in the situation. She should consider all such influences when writing reports on her visits so that her evaluation, based on observation plus special preparations and experience leading up to her role as consultant, will be truly objective and not distorted by personal feelings. The consultant must not only have the courage to state her evaluation, but also she must learn to live with her decisions. This is a difficult task at times, but adequate preparation and experience will stand her in good stead for this function.

Listening

This is one of a consultant's most valuable assets and requires special preparation. Training and experience in personnel administration, and non-directive counselling, are very helpful in the development of this faculty. This approach creates a feeling of warmth and promotes good rapport in any interview and allows the nurse to find her own solution through verbalizing her problem to the consultant. A member of management should also be present at the discussion of problems in order that all persons concerned may understand each other's viewpoint. The consultant functions as the backdrop in the stage setting. This is not a new concept; in fact, Robert Burns, the Scottish poet, expressed the same opinion when he stated:

> "O Would some power the giftie gie us
> To see oursel's as other see us".

The Incubation of Ideas

It is difficult at times for an expert to await the development of ideas; the consultant wishes to get on with the job, but in her role, she must wait for some action on the part of those who have received the benefit of her service. Sometimes it may be weeks, or even months before any response is forthcoming from ideas presented, on request, to nurses and members of management, but it is very important in the consultation process that she share the development with those involved.

As well as an incubation period, there is the diagnosis of symptoms. In this respect, the consultant should use her intuition on the question of when to step into a situation and when to step out and allow the situation to be carried on its own momentum.

Talent Scout

Nursing needs more hands for the leadership job and the consultant has an excellent opportunity to find potential leaders as the field of occupational health nursing has a rich supply. One of the satisfactions of the consultant's job is to observe evidence of these special abilities and to help the nurse develop her own leadership pattern. The development of talent or special abilities is inherent in the "Consultative-Participative" philosophy so ably described by Robert McMurray in his article, "Man-Hunt for Top Excutives" (2). The characteristics described are those of the leader who creates the democratic social climate. In this situation the leadership is strong; there is promptness and soundness in decision-making, willingness to accept responsibility and defend a position taken, and demonstrated planning and organizational ability. The leader encourages creative abilities in those under his guidance. Through shared leadership, ego-gratification of the members is recognized and encouraged. Common goals are stated which give a feeling of belonging to a larger group of workers in the field. This reduces friction because it meets a basic need in each person. The democratic leader can permit group participation, criticism and scope for experimentation because he has superior technical knowledge himself, is qualified by competence and character to gain and hold the loyalty of the group members, and retains the leadership of the situation at the same time that he delegates authority. The nursing consultant in the occupational health field of necessity must have these qualifications of the democratic leader so that she may develop the leadership qualities found in the plant nurse. Thus out of our field the nurse will assume added leadership responsibilities as a part of the total nursing service to her nation. The responsibilities are shared by the plant nurse and the consultant which make it the "Consultative-Participative" philosophy.

Public Relations

Adequate communications are very important for the development and progress of any field of endeavour; for example, a manufacturing industry would not consider marketing a commodity without telling the prospective consumer about it. Similarly, the occupational health nurse, in addition to rendering good professional service, must do an equally efficient job of interpreting this service to all who may be concerned with the health of people at work. Facts about nurses and nursing should be drawn up systematically by the nurses and presented in a positive, well-integrated manner through the medium of a well-defined program. The consultant is aware that information on occupational health nursing should originate with, and be promoted by, the plant nurses who are the key individuals in this branch of nursing.

A well-organized program of public relations, planned and operated on the basis of the principles and techniques which have been developed by this young science, provides the consultant and the nurse with an invaluable medium through which they can make their most effective contribution. The structure of a public relations program may be likened to the pattern of cir-

cles surrounding the point at which a pebble has been dropped into a pool of still water, at the central point of the pattern is the nurse and the circles represent the various sections of the public with which she wishes to communicate.

The 'Publics' of each plant nurse see her at work in the health centre and when she visits the various work areas; they form their opinions of nurses and nursing through the example and teachings of the nurses who serve them. Should misinformation or unfavourable impressions about nursing be apparent in the minds of the public, it is for the occupational health nurses to see that the situation is corrected as quickly as possible. For this reason, nurses must be agreed on the impression they wish their 'Publics' to have. When consultants and plant nurses make this a shared responsibility as a part of the total public relations of the nursing profession, they will be assuming one of their greatest responsibilities.

Many of the facts about nursing, which are taken for granted by nurses, may be difficult to express. For this reason, it is a good exercise for an industrial nurse to attempt, without references, to define her position and enumerate the objectives, functions and scope of her work. This practice will help to crystallize her thinking and give her an objective picture of her situation in relation to the nursing profession as a whole. Such a practice was suggested during the presentation of this paper to the nurses registered in the occupational health nursing course at New York University.

In closing may I leave with you four challenges or responsibilities by which we may develop the "Consultative-Participative" philosophy working towards a true partnership between the consultant and the nurse in the plant health service of private industry.

1. Because the nursing consultant is chosen to give leadership, you, as individual plant nurses, should support the consultant, who, if properly selected, will interpret, promote, and support the professional services of the plant nurse in occupational health.

2. Each industrial nurse should develop her own public relations program and make it correlate with her immediate industry's public relations program as well as the overall National, State or Provincial, and local nursing programs. Assure that nurses originate the facts about nurses and that the pressures flow from the centre of the circles upon which the public relations program is plotted.

3. As professional people, we must develop a body of scientific knowledge, principles and techniques for occupational health nursing and we must also communicate these to all who are concerned with health services to citizens at work.

4. As nurses we should step up and assume our responsibilities for the supply of nurses and nursing services so that we may conserve this scarce commodity on the employment market. Nursing is an essential service to the health and well-being of our people at work.

All this is truly a partnership with broad horizons.

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Physicians Indoctrination Course

(Continued from page 3)

Conclusion

No attempt has been made in this account to try to outline the actual instruction given on this very comprehensive one week course. These are, with all their shortcomings, a few of the impressions and thoughts of one of the class, who found it to be of very real value. The physician must take a leading part in civil defence; this, surely, needs no elaboration, and the aims of civil defence cannot be better expressed than in again quoting from the Minister's opening speech:

"In conclusion, let me stress that the value of civil defence to a community goes far beyond its immediate objectives. Besides their potential for protection in time of war, civil defence measures can have valuable peace-time application as well. In a serious peace-time disaster, a well-equipped and properly-trained civil defence force can be of inestimable value in maintaining public morale and in restoring normal conditions quickly in the stricken community.

The peace-time application of civil defence measures serves to underline one essential fact: that every civil defence activity has a humanitarian purpose, for the object of civil defence is not destruction but restoration—not to take life but to save it."

Rehabilitation

(continued from page 5)

working with the rehabilitation of the handicapped due to the rheumatic diseases, that you search primarily for the assets of the individual; that the patient needs your psychological help and understanding; that you think of the patient as a human being rather than arthritis with a human being attached; that you recognize his fears, anxieties, phobias, likes and dislikes; and that you not try to put him in a class. From the psychological point of view, each patient is an individual and he does not suddenly, with the advent of the disability, become undifferentiated from his fellow men.

These are facts which I'm sure you have been familiar with in one form or another. It was my purpose to lend weight to these facts based upon our research. These are not just incidental findings. In the vocational rehabilitation of the disabled, one has to give great weight to the total problems of these individuals and not just their physical problems.

Philips Health Centre

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and a close contact between all these sections was brought about. It was this beneficial group work, stimulated by the (to use a medical term) contagious conviction of Prof. Burger, who devoted, and still devotes, his entire personality to the creation of what he sees as an ideal industrial medical group, which shaped the present organization of the Health Centre.

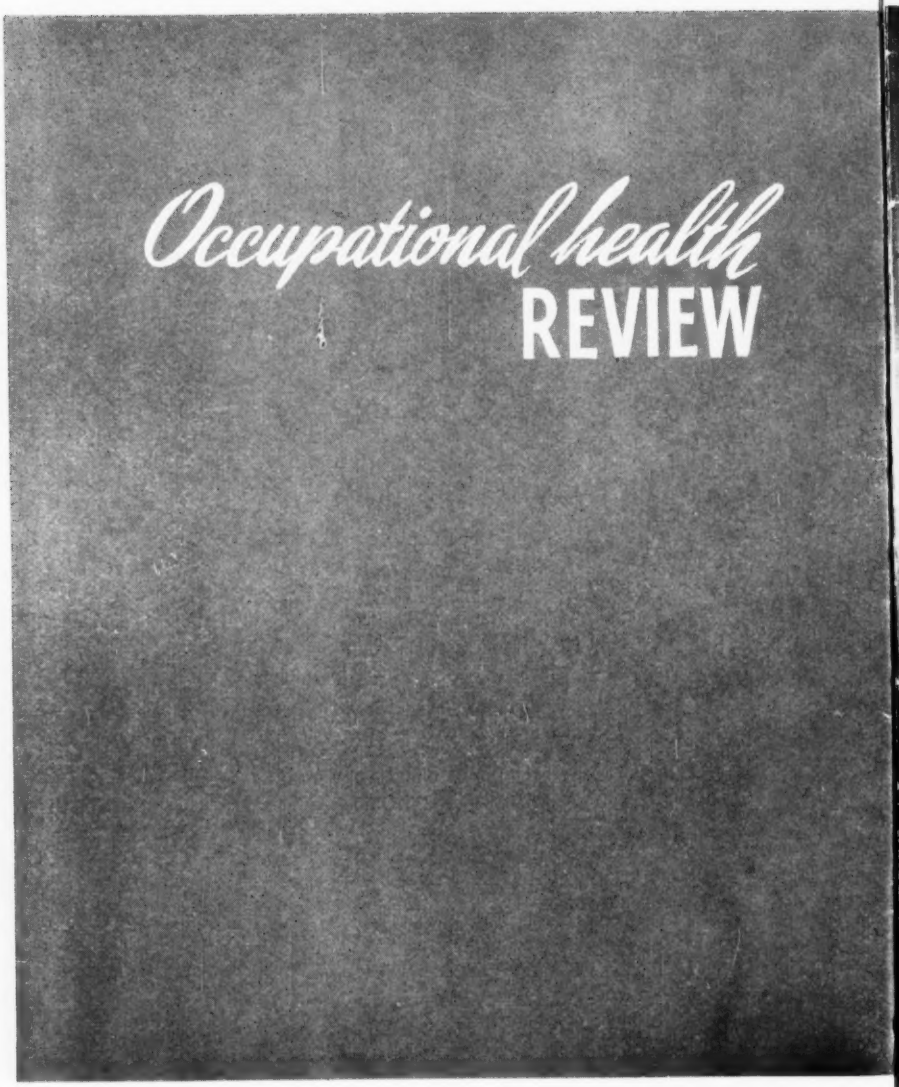
To serve both the individual and the concern in equal measure is the difficult and often contradictory aim of the medical department. It is closer to reaching it than any industrial physician could ever have dreamed of.

British Occupational Hygiene Society

(continued from page 11)

of the British Occupational Hygiene Society, a learned association of workers in all spheres of occupational health. This society was formed in 1953 to further the aims and ideals of occupational health in Britain.

Edmond Cloutier, C.M.G., B.A., L.Ph.
Queen's Printer and Controller of Stationery, Ottawa
1955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